

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Medicare Beneficiary Access
to Home Health Agencies**



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Inspector General**

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OFFICE OF INSPECTOR GENERAL

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SUMMARY

This inspection assesses how the interim payment system (IPS) for home health agencies is affecting Medicare beneficiaries' access to home health care for patients discharged from hospitals. Our analysis is based on a telephone survey of a national random sample of 181 discharge planners and Medicare home health data. We found that 85 percent of discharge planners report that Medicare patients are able to obtain home health care when they need it, three quarters of the discharge planners need to contact only one home health care agency on average to obtain care for their patients, and 83 percent say home health care agencies either never or infrequently refuse to take Medicare patients. We also learned that home health agencies have changed their admissions practices over the past two years by requiring more information before accepting a prospective patient. Those discharge planners who indicate that they had problems in placing some home health care patients attribute it to Medicare eligibility requirements as well as the interim payment rate.

PURPOSE

To assess how the interim payment system (IPS) for home health agencies is affecting Medicare beneficiaries' access to home health care, primarily for patients discharged from hospitals.

BACKGROUND

The Health Care Financing Administration (HCFA) asked the Office of Inspector General (OIG) to assess if the interim payment system for home health agencies is causing access problems for Medicare beneficiaries. In addition, HCFA also asked the OIG to examine home health payment error rates, repeating its 1997 audit of error rates in California, Illinois, New York, and Texas. The home health industry as well as beneficiary advocates have raised concerns that the IPS is adversely affecting Medicare beneficiaries' access to home health care.

Medicare Home Health Care Home health care consists of skilled nursing, therapy (physical, occupational, and speech) and certain related services including aide services furnished in a patient's home. Services are typically provided by registered nurses, therapists, social workers, and home health aides employed by a home health agency (HHA). These agencies can be freestanding or facility-based and classified as not-for-profit, proprietary, or governmental. Studies have suggested that most high users of home health care have long-term care needs. More than nine in ten high users have limitations in activities of daily living, and most have multiple, complex medical needs.

Medicare will pay for home health care only if it is reasonable and necessary for the treatment of a patient's illness or injury. In order to be eligible for the Medicare home health benefit, beneficiaries must be homebound and require intermittent skilled nursing or physical or speech therapy; he or she must also be under the care of a physician.

Beneficiaries can receive any number of home health visits if these visits are certified as necessary by a physician and are furnished under a prescribed plan of care that is periodically reviewed by the physician.

Until recently, Medicare payments for home health services were growing rapidly. From 1990 to 1996, Medicare payments grew from \$3.7 billion to \$16.9 billion. This expansion was concentrated in certain regions of the country, such as the South and Southwest, and among certain types of HHAs. Freestanding and urban agencies doubled, while the number of proprietary agencies tripled. The duration of home health care services also increased; while 14 percent of all home health episodes lasted 166 days or longer in 1990, about 20 percent of all episodes lasted this long in 1995.

Beginning in 1995, several initiatives were implemented to address concerns about fraud and abuse and to control the costs of Medicare home health. These included the creation of an anti-fraud campaign entitled Operation Restore Trust, changes to Medicare participation rules designed to screen out problem providers, and payment limits created by the Balanced Budget Act of 1997 (BBA) .

The Balanced Budget Act and Interim Payment System The BBA changed the way Medicare pays for home health care. The law requires a payment change from a cost-based method to a prospective payment system (PPS) of fixed, predetermined rates for home health services. Until this PPS is developed, however, home health agencies are reimbursed under an interim payment system (IPS) which imposes payment limits on their services. The IPS was implemented on October 1, 1997, and will continue to be in place until the PPS begins on October 1, 2000.

The IPS is intended to control the aggregate costs of services provided to beneficiaries. In addition to reducing the per-visit limit, it subjects Medicare HHAs to a new payment limit that is based on an aggregate per-beneficiary amount; this cap is applied to an agency's total Medicare payments and does not limit payments for specific beneficiaries. The IPS is based on fiscal year 1994 expenditures and is updated annually for inflation. Agencies that were Medicare certified for the fiscal year ending October 1, 1994 and had filed a full 12-month cost report for that period have an aggregate per-beneficiary amount calculated as 98 percent of a blend of 75 percent of its own fiscal year 1994 per-beneficiary payment and 25 percent of the regional median average. For agencies that were not Medicare certified in fiscal year 1994 or did not have a full 12-month cost report for that year, the aggregate amount is based on the national median. The Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 made several changes to the payment limits, including increasing the per-visit limits for all agencies and increasing the aggregate beneficiary limit for certain agencies. Agencies can use several methods to keep costs below their payment limits, including balancing their mix of low and high cost patients, reducing their costs overall, and increasing their proportion of low-cost patients.

The IPS does appear to be having some impact. The number of beneficiaries served and the number of visits per user are below peak 1996 levels. The decline in visits per user over the past two years appears to be consistent with IPS incentives and may or may not imply problems with access. Also, 14 percent of agencies have closed between October 1, 1997, and January 1, 1999. About 40 percent of these closures were in three States - Louisiana, Oklahoma, and Texas. In all three States, however, the number of HHAs per Medicare beneficiary exceeded the national average. Most agencies that stopped serving Medicare beneficiaries were also more likely to be high-utilization, low-volume agencies. It is, however, difficult to differentiate the effects of IPS from other BBA reforms and improved program integrity efforts.

Access Concerns The home health industry has expressed concerns that payment limits established under IPS are restricting access to care for the sickest and most expensive Medicare populations. The industry also believes that these limits are too stringent and have caused some agencies to close, which has decreased access to home health for some patients.

Several reports have been released this year that discuss home health care access. A General Accounting Office (GAO) report found that overall beneficiary access was not affected by recent agency closures but did suggest that as agencies change their operations in response to IPS, beneficiaries whose treatment costs are higher than average may have increased difficulty in obtaining home health care. Also, the Medicare Payment Advisory Commission (MEDPAC) reported a decline in agency supply and concerns about impaired access for patients with expensive care needs; it does not, however, directly attribute all of these changes to IPS. Finally, a George Washington University study reported that agencies are altering admissions standards and reducing care for patients with severe chronic illness, especially diabetics.

Additionally, some advocacy groups have voiced concerns about access. Four of the five national advocacy groups interviewed for the GAO report reported receiving access complaints about individuals with chronic illnesses or conditions such as Alzheimer's disease and multiple sclerosis.

Discharge Planners Each hospital is required to have a discharge planning process in place. Patients may be discharged to a variety of settings. These include a patient's home, with or without services from a home health agency, or a nursing home. Data show that in 1998, most Medicare discharges (60 percent) were to homes, while 15 percent were to skilled nursing facilities, 10 percent were to home health, 3 percent to intermediate care, and the remaining 13 percent to some other entity.

There appears to be no single model for a hospital discharge planning process. Definitions of what discharge planning involves and the organizational structures of the departments and professional credentials of the discharge planning staff vary from hospital to hospital.

The social work or nursing department often has the primary responsibility for discharge planning, generally with input from other healthcare team members. The responsibility is sometimes in the case management or utilization review department.

Effective discharge planning identifies the patient's post-hospital needs early to ensure discharge to a safe environment with the appropriate level of services. Once a determination has been made that a patient needs discharge planning, the discharge planner conducts a psycho-social assessment and meets with utilization review staff, the patient's nurses and physicians, or other relevant interdisciplinary team members, to discuss the patient's care plan. Early on, the discharge planner solicits the patient's preferences and concerns, and reaches out to the family or other potential care givers to get their input and cooperation. As the discharge planner gains a clearer understanding of the level of care that the patient needs after discharge, he/she analyzes the patient's insurance coverage in an effort to match the patient's needs for services with those for which they are eligible.

METHODOLOGY

We combined two methods for this inspection: telephone interviews with hospital discharge planners and analysis of HCFA home health data. From a national random sample of 200 hospitals, we completed interviews with 181 discharge planners during a two week period from September 13 to September 24, 1999. The remaining 19 either did not discharge Medicare beneficiaries with home health agencies or could not be reached. In addition, we conducted follow-up interviews with 24 of 28 discharge planners who reported not always being able to get home health care for Medicare patients who need it. (We were unable to reach the other four.) Where appropriate and possible, we analyzed HCFA home health claims data to supplement discharge planner perspectives.

There are several limitations to our methodology. First, by obtaining the perspectives of hospital discharge planners, we are only able to discuss home health beneficiaries with prior hospitalizations; approximately one-third of Medicare beneficiaries have been hospitalized prior to receiving home health care. Second, we report 1999 Medicare home health data for the first 6 months of the year, due to time lags in claims submission this data may not be complete.

FINDINGS

Most discharge planners believe Medicare beneficiaries are able to obtain home health care upon hospital discharge, but they note changes and raise concerns

Access

- ▶ Most discharge planners (85 percent) report that Medicare patients are able to obtain home health care when they need it, but 15 percent say home health care is not always available. No difference is noted between discharge planners from urban and rural hospitals, or from hospitals with a financial interest in an HHA and those without one.
- ▶ Most discharge planners (83 percent) report that it is either not difficult or only minimally difficult to place Medicare patients with home health agencies.
- ▶ Three-quarters of discharge planners report needing to contact only 1 home health agency on average to obtain care for their Medicare patients, and 83 percent say home health agencies either never or infrequently refuse to take Medicare patients.
- ▶ According to HCFA Medicare data, hospital discharges to home health care appear to remain constant. The proportion of Medicare discharges to home health care was 11 percent in the first 6 months of 1997 and 10.9 percent in the first 6 months of 1999.
- ▶ The 15 percent of discharge planners (28 of 181) who report that they are not always able to place Medicare beneficiaries with home health care cite two main causes.

Medicare Coverage- Thirteen of 24 discharge planners note that Medicare does not cover home health care if the patient does not require skilled care or is not homebound or state that Medicare no longer always pays for IV medication or considers venipuncture a skilled need. (Seven of those who cite Medicare coverage say this access problem has not changed in the past 2 years.)

Interim Payment System- Ten of these 24 discharge planners believe that the new reimbursement system has had the effect of making agencies more selective of the patients they accept, reducing HHA staff, or contributing to a decrease in the number of HHAs.

The remaining discharge planner cites being in a rural area with limited access to HHAs as the primary reason for being unable to place beneficiaries.

- ▶ Of the 24 discharge planners who report that Medicare beneficiaries are not always able to obtain home health care, 11 say they were unable to place 5 percent or less of their home

health patients, 4 report a 10 percent problem, and 9 estimate being unable to place between 20 and 50 percent of these patients.

- ▶ Discharge planners who report that Medicare beneficiaries are unable to obtain home health care say that these beneficiaries most typically go to a nursing facility, have extended hospital stays, or are discharged home under the care of family and friends.

Changes

- ▶ A majority of all discharge planners (61 percent) report that home health agencies in their area have changed their admissions practices over the past 2 years. The primary change they report is that agencies are requiring more information about prospective patients before accepting them.
- ▶ Supporting this, 60 percent of discharge planners who are familiar with IPS believe this system has made the process of placing Medicare patients with home health agencies more difficult. They report needing to provide more information on prospective patients in order for agencies to evaluate Medicare eligibility, to assess service needs and related costs, or to better manage their case mix.
- ▶ More than half of the discharge planners report that each of the following subgroups of patients has become more difficult to place: patients with chronic health care needs; IV care; high cost care; and intensive care. More than half also note that patients diagnosed with Alzheimer/dementia and renal failure (dialysis) patients are more difficult to place.

Concerns

- ▶ Just over one-quarter of discharge planners volunteer during our interviews their concern that some Medicare patients may not be receiving the length of care or the adequacy of services they need. These discharge planners, for example, cite higher hospital re-admission rates and increasing use of hospital emergency rooms as indications that patients may not be getting the home health care they need.

COMMENTS

The Health Care Financing Administration provided comments to both the audit report on payment error rates and this report. They were grateful for the information and happy to note that the overwhelming majority of Medicare beneficiaries are receiving the home health care they need. At the same time, they requested us to continue our work in this area. This work is currently underway.

The full comments from HCFA are attached.



OCT 26 1999

Deputy Administrator
Washington, D.C. 20201**DATE:****TO:** June Gibbs Brown
Inspector General**FROM:** Michael M. Hash *Michael M. Hash*
Deputy Administrator**SUBJECT:** Office of Inspector General (OIG) Draft Reports: "Review of Medicare Home Health Services in California, Illinois, New York, and Texas," (A-04-99-01194) and "Medicare Beneficiary Access to Home Health Agencies," (OEI-02-99-00530)

We appreciate the opportunity to comment on the above-referenced reports. Both studies were conducted at our request, and they address important questions for us and home care beneficiaries, providers, and advocates regarding program integrity and access to care.

In the past year, we have taken a series of steps to strengthen the home health benefit for Medicare beneficiaries. Home health care enables seniors and disabled Americans, and the frailest beneficiaries, to receive many services in their homes as covered under Medicare law. We are committed to protecting the benefit for those who qualify for it.

General Comments

The Balanced Budget Act of 1997 (BBA) addressed a number of concerns regarding Medicare payment for home health services. For example, it stopped the practice of billing for care delivered in low cost, rural areas from urban offices at high urban-area rates. It tightened eligibility rules so patients who only need blood drawn no longer qualify for the entire range of home health services. And, it created an interim payment system to be used while we develop a prospective payment system. We expect to publish a proposed regulation by the end of this month and to have the prospective payment system in place by the October 1, 2000 statutory deadline.

The interim payment system is a first step toward giving home health agencies incentives to provide care efficiently. Before the BBA, reimbursement was based on the costs they incurred in providing care, subject to a per visit limit, and this encouraged agencies to provide more visits and to increase costs up to the limits. The interim system includes a new, aggregate per beneficiary limit designed to provide incentives for efficiency that will be continued under the episode-based prospective payment system. Last year Congress increased the cost limits in an effort to help agencies during the transition to

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prospective payment. We are also taking the steps discussed above to help agencies adjust to these changes, and in March we held a town hall meeting to hear directly from home health providers about their concerns. Another is scheduled for this November.

To date, evaluations by the Government Accounting Office (GAO) and Department of Health and Human Services have found that BBA changes are not causing significant quality or access problems. Our monitoring of employment data shows that freestanding home health agencies have made small reductions in their workforce, back to the level seen in 1996. However, we have heard reports from beneficiary groups, our regional offices, and others regarding home health agencies that have inappropriately denied or curtailed care, and incorrectly told beneficiaries that they are not eligible for services. We are also hearing reports from beneficiary advocates and others that some high cost patients are having trouble finding home health agencies to provide the care they need. This may result from a misunderstanding of the new incentives to provide care efficiently. The Congressional Budget Office attributes some of the lower home health spending to the fact that agencies are incorrectly treating the new aggregate per beneficiary limit as though it applies to each individual patient.

We have, therefore, provided home health agencies with guidance on the new incentives and their obligation to serve all beneficiaries equitably. We have instructed our claims processing contractors to work with agencies to further help them understand how the limits work. Because home health beneficiaries are among the most vulnerable, we are continuing ongoing detailed monitoring of beneficiary access and agency closures.

Our specific comments on each report are attached.

Attachment

"Review of Medicare Home Health Services in California, Illinois, New York, and Texas." (A-04-99-01194)

We believe we have made great progress in reducing payment errors in home health in the four states studied. As with the national error rate reflected in the 1998 Chief Financial Officers Act report, the payment error rate has been reduced by more than half in just two years. More progress must be made on this front, but the increased compliance with Medicare rules reflects the hard work of many partners in the system--home health providers themselves, contractors, agency employees, law enforcement, and beneficiaries--to ensure that we pay correctly.

The nature of the errors identified is instructive and helpful in our efforts to continue to assure that we pay Medicare claims properly. Errors resulting from services not reasonable and necessary declined 70 percent, as did errors resulting from determinations that the beneficiary was not homebound and errors resulting from a lack of physician orders. However, these were partially offset in the OIG's calculations by a new error category. A number of errors in the sample (128, or 5.8 percent as a component of the 19 percent error rate) are attributable to a lack of response from home health agencies that have left the program. Because the OIG could not locate these agencies or their owners, they failed to provide any medical records at all. Our records reflect that these home health agencies have merged with other operations or have closed altogether, generally ceasing operations in the earlier part of 1999.

We agree that it is a problem that these records could not be obtained. Typically, when records are not produced to substantiate a claim, the claim is determined to be an error. But in these cases, we can not establish that the agency management or owners received the request for the records, because the OIG could not locate them. The report does not provide detail on the steps taken by the OIG to obtain a current address, though it does say that the auditors made numerous attempts to find the agencies, even going so far as to contact beneficiaries themselves.

We are particularly concerned about this finding because it represents the most significant error category in the OIG's audit, and because agencies leaving the program with uncollected overpayments has been of concern to us. Most of the 12 agencies in this category, according to our records, do have outstanding overpayments and we will be unable to collect on these overpayments if we cannot locate the owners.

Further, if these agencies were located and their records reviewed, it is possible that the error rate estimate by the OIG would have been lower. For example, if the records from these agencies contained the same percentage of errors as those in the sample as a whole, the error rate estimate could have dropped several points. Therefore, we plan to work with the OIG to obtain further information on these agencies and determine if the

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available sources at contractors, survey agencies and regional offices can yield further data to assist us in obtaining records and updated addresses for owners and records retention sites.

OIG Recommendation

HCFA should revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days.

HCFA Response

We agree with the OIG's concern for the importance of the physician role and share their concern that some errors can be attributed to the lack of adequate physician supervision. We will be considering options to address this issue in the near future including increased physician education as well as other mechanisms to encourage physician involvement. While we agree with the need for more physician involvement, this requirement would require a change in a law and potentially increase program costs. We would need to consider the impact on beneficiaries, particularly in rural areas. We will need to determine whether payment errors occur more frequently, and with what impact, when physicians do not examine patients prior to signing a plan of care than when they do provide such an examination. We also believe our reliance on composite review of Outcome and Assessment Information Set data and physician plans of care in medical review will cause agencies and physicians to form clearer relationships in care planning and service delivery.

OIG Recommendation

HCFA should consider the 19 percent rate of improper or highly questionable services as a factor before making any changes to the current payments under the interim payment system (IPS).

HCFA Response

Under current law, we lack the statutory authority to make changes to current payments under IPS. As a result, we have not recommended any changes to the IPS at this time.

OIG Recommendation

HCFA should consider making an equitable adjustment to the proposed home health agency prospective payment system rates or update factors to take into account the improper and highly questionable payments that were included in the base year calculations.

HCFA Response

We do not concur with the recommendation because HCFA has already taken several steps to ensure accurate and fair payments. First, the law requires us to use most recent audited cost report data available for the base year. In this connection, we conducted a statistically representative sample of home health agency cost reports. We conducted comprehensive audits of the cost reports submitted by the sample home health agencies. The scope of these audits went well beyond our usual level of effort and the industry has complained that this level of audit resulted in a higher level of disallowances than ordinarily would be the case. Thus, we believe that the cost report data we are using to establish the costs of individual service components of the rates has been properly analyzed and does not reflect significant excess cost.

Second, we believe that the OIG's current report demonstrates that agency responses to the IPS have significantly reduced the level of questionable claims and payments. The combination of these two factors and the imposition of an additional 15 percent reduction in payments as required by law appears to us to create a payment situation in which further examination and manipulation of the cost base is no longer necessary for pricing the services. Instead, we believe that the Congress has set the overall price of services and intends that it be updated annually by a market basket adjustment. On the other hand, we recognize that this is an issue that merits further review and we are asking for further comments on it in the Notice of Proposed Rule Making we are publishing.

OIG Recommendation

HCFA should instruct the intermediaries to collect the overpayment identified in our sample.

HCFA Response

We concur, subject to the need for further development of claims for terminated home health agencies, as discussed above.

"Medicare Beneficiary Access to Home Health Agencies." (OEI-02-99-00530)

We are encouraged that this report documents that access to home health services have, in large measure, been maintained. As noted above, we are undertaking a number of activities to assess and monitor access to care and appreciate the data presented in this report. It adds to the other information we have and are gathering in order to allow us to understand and develop appropriate responses to access problems if and when they occur. We reiterate our commitment to ensuring beneficiaries have access to Medicare covered benefits.

Access to care must be viewed in the context of historical coverage and utilization. Unfortunately, there are always instances when a beneficiary with one set of needs does not find a home health agency available which can meet them. These situations occurred even before IPS. However, we do not have an "access" baseline to which we can now compare changes. Available data such as expenditure levels or total numbers of home health providers are not appropriate proxies. For example, as evidenced by the companion OIG report being issued, inappropriate utilization has decreased by more than 50 percent over a period of a few years. We believe that the reasons home health agencies may be giving for declining patients who they may previously have accepted for care must be understood in this context.

We continue to collect and analyze data relating to access, not only for home health beneficiaries who are discharged from the hospital, but also for those home health beneficiaries who come from the community. We encourage the OIG as well as the GAO, to continue working with us on these issues.

We are particularly interested in knowing more about the concerns of discharge planners suggesting some agencies may not be providing adequate services to the Medicare beneficiaries under their care. We urge OIG to study, as we will do, the available data to determine if home health patients are returning to the hospital more frequently than in the past.

Medicare law and regulations require that home health agencies provide all Medicare covered care when they agree to care for a beneficiary who qualifies for the home health benefit. We have reminded agencies repeatedly of this responsibility since we implemented the changes in the payment system required by the BBA. In addition, to assure the quality of home care, we now require agencies to use a standard assessment tool that will allow both Medicare and the agencies to identify patterns involving the quality of care that individual agencies provide and the outcomes for their patients. That tool will help us identify and take appropriate steps to ensure the quality of care for beneficiaries.